Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NATIONAL SPECIALIST PALLIATIVE CARE REFERRAL FORM

Please forward the completed form to your local service provider.

Local Services may be identified using the HSE Area Finder
Click Online Referral Form for further copies
Click here for the Eligibility Criteria for SPC Services - access and discharge
Click here for the Palliative Care Needs Assessment Guidance

Patient Details

Name: **Address:** **Eircode:**	**Date of Birth:** **Contact Tel Nos.:** **PPS No.:**	**Sex at Birth:** **Preferred Language:** **Translator Required:** Yes ☐ No ☐ **Medical Card:** Yes ☐ No ☐ **Medical Card No.** (If applicable):
Current Location:	**Patient Lives Alone?:** Yes ☐ No ☐	

Main Contact Person – Family/Carer/Representative

Contact Name: **Phone No.:**

Relationship: **Address:**

Eircode:

First Contact in an emergency (if not the above): **Phone No.:**

Relationship:

Referral for which Specialist Palliative Care Service: ☐ Admission to Hospice/Inpatient Unit* ☐ Community Based Services*/** ☐ Hospital Inpatient Review ☐ Hospital Outpatient Review ☐ Other(Specify): *Subject to triage & availability. **May also include OPD, SPC Day Unit, or other.	**Urgency of Referral:** (Subject to Triage by Specialist Palliative Care Team) ☐ Within Two working days* *Referral must be accompanied by phone call from referrer ☐ Within One Week ☐ Within Two Weeks ☐ For Information Only

Diagnosis, (cancer or non-cancer) previous and current treatments, recent hospital admissions & future treatment plans

Please attach relevant correspondence, bloods, and imaging results. Incomplete information may delay triage and first assessment

Future Care Plan/Treatment Escalation Plan in place Yes ☐ No ☐ Unknown ☐ If yes, please describe:

Advance Healthcare Directive in Place: Yes ☐ No ☐ Unknown ☐ DNACPR decision in Place: Yes ☐ No ☐ Unknown ☐

Active or anticipated problem(s)/reason(s) for referral:
Consider Physical, Psychological, Spiritual, Social, Family/Carer domains

Other Medical Conditions +/- Infection Control issues (e.g., MRSA, VRE, CPE, KPC, others):

Patient's Name:	**Date of Birth:**	**PPS No.:**

Current Medications – doses and significant recent changes:

Known drug allergies/ Side-effects/Sensitivities to medications/dressings etc.:

Equipment/devices currently in use

Long Term O_2 Therapy: Yes ☐ No ☐	**Active Implantable Cardioverter Defibrillator** (ICD): Yes ☐ No ☐
Non-Invasive Ventilation: (Please specify type):	**IV Access/Port** (Please specify type):
Tracheostomy: Yes ☐ No ☐	**Clinical Equipment** (Please specify type):
	Miscellaneous Equipment (Please specify type):

Australian-Modified Karnofsky Performance Status (AKPS):

☐ 100.	Normal, no complaints or evidence of disease	☐ 50.	Requires considerable assistance and frequent medical care
☐ 90.	Able to carry on normal activity, minor signs or symptoms of disease	☐ 40.	In bed more that 50% of the time
☐ 80.	Normal activity with effort, some signs or symptoms of disease	☐ 30.	Almost completely bedfast
☐ 70.	Care for self, unable to carry on normal activity or to do active work	☐ 20.	Totally bedfast & requiring nursing care by professionals and/or family
☐ 60.	Occasional assistance but is able to care for most needs	☐ 10.	Comatose or barely rousable

Estimation of Prognosis: Awareness of diagnosis, prognosis, and referral to specialist palliative care

Estimation of Prognosis: (Please tick one) **Days** ☐ **Weeks** ☐ **Months** ☐ **Years** ☐

Patient aware?:		**Are Family and/or Carer aware?:**	
Diagnosis:	Yes ☐ No ☐ Unsure ☐	**Diagnosis**:	Yes ☐ No ☐ Unsure ☐
Prognosis:	Yes ☐ No ☐ Unsure ☐	**Prognosis**:	Yes ☐ No ☐ Unsure ☐
Referral:	Yes ☐ No ☐ Unsure ☐	**Referral**:	Yes ☐ No ☐ Unsure ☐

Any other relevant information:
(e.g., other contact details, family or other domestic issues of concern, other health care professionals involved, etc.)

Details of GP and Consultants involved in the patient's care.

GP's Name: **GP's Phone No.:** **GP's Address:** **GP Aware of Referral**: Yes ☐ No ☐ **Is the GP content to complete a death notification form in the event of an anticipated death?:** Yes ☐ No ☐ Unsure ☐	**Consultant's Name(s):** **Hospital Location(s):**
Referred by: **Name:** **Job Title:** **Place of Work:** **Contact Tel No/Bleep:**	**Referrer's Signature:** **Referrer's Registration No:** **Date:**